MEDICAL CLAIM FORM

PLEASE COMPLETE ONE FORM PER PATIENT

1. Complete all questions in sections A B C and D.

A. Employer Information.

Name of Your Employer	Group Number as shown on your ID Card

B. Employee Information.

❑ **check here if new address**

Employee's Last Name	First Name	Middle Initial	Employee's Social Security Number
			— —

Home Address	Employee's D.O.B.
	/ /

City	State	Zip Code

C. Patient Information.

Patient's Last Name	First Name	Middle Initial	Relationship to Employee
			❑ Self ❑ Spouse ❑ Child

Patient's D.O.B.	Patient's Social Security #	If over 19, is child a full time student? ❑ Yes ❑ No If yes, school attended:
/ /		

D. Other Group Health Plan Information.

Spouse's D.O.B.	Is Spouse employed? ❑ Yes ❑ No Employer Name ____________	If yes, does Spouse have health coverage thru employer? ❑ Yes... ❑ No — Single ❑ or Family ❑
/ /		

Is Patient covered by any other Group Health Plan? ❑ Yes ❑ No

If yes, *COMPLETE THIS SECTION TO EXPEDITE YOUR CLAIM.* If no, proceed to Section 2.

Other Group Plan Name	Indentification / Policy No.

Insurance Company Name and Address

City	State	Zip Code

2. Complete the sections which apply to your claim.

E. Second Surgical Opinion Information.

Is this claim for a Second Surgical Opinion? ❑ Yes ❑ No — If yes, name Physician who ***FIRST*** recommended the surgery:

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F. Accident or Work Related Injury information.

Is this claim due to an accident? ❑ Yes ❑ No	If yes, where did the accident occur?	Date of accident
	____________________	/ /

Describe accident:	Is this claim the result of a work related illness or injury? ❑ Yes ❑ No
____________________ ____________________	

3. Complete only if you wish payment to be made directly to doctor, hospital, or other medical service provider.

G. Direct Payment Authorization.

Name of Doctor, Hospital, or other Medical Service Provider

City	State	Zip Code

Phone number ( )

Employee's signature authorizing direct payment to provider	Date
	/ /

4. *Must* be signed & dated by Employee.

H. Authorization to Release Medical and Insurance Information.

To any physician, medical practitioner, hospital, clinic or other medically related facility or provider of medical services or supplies, and any employer, group policyholder, or contract holder or insurer, I authorize you to release to First Administrators, Inc. or to its representatives any and all information you may have about the mental and physical history, condition and treatment, and insurance coverage for the Patient named in Section C above.

I understand the information obtained by First Administrators, Inc. will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by First Administrators, Inc. to any person or organization EXCEPT to reinsuring companies, Group Policyholder, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required or as I may further authorize. For the purpose of disclosing information, I understand that this authorization is valid for a period of one year. I know that I may request a copy of this authorization. If this authorization is given in connection with a claim for health benefit, disability or life insurance benefits, I understand that it is valid for the duration of the claim. A photocopy of this authorization shall be as valid as the original.

I verify the above information is true and accurate.

Employee's Signature	Date
	/ /

5. ATTACH THE BILLS FOR THE MEDICAL EXPENSES YOU ARE CLAIMING. THE BILLS MUST BE ITEMIZED AND SHOW THE PATIENT'S NAME, DIAGNOSIS, TYPE OF TREATMENT AND DATE OF SERVICE.

Please send the completed claim form and appropriate statements to:

First Administrators, Inc. – Claims Department
P.O. Box 9900, Sioux City, Iowa 51102
Toll Free 1(800) 206-0827
Local (712) 279-8400

TO BE COMPLETED BY PHYSICIAN OR OTHER PROVIDER OF MEDICAL SERVICES

Please complete the following information or attach itemized bills, receipts, and statements of charges from all physicians, hospitals, and any other sources. These statements must contain the following:

A. Patient's name.
B. All service or supplies provided.
C. The charge for each service provided.
D. The date each service or supply was provided.
E. Diagnosis or illness involved.

PHYSICIAN OR SUPPLIER

Date of Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP) / /	Date First Consulted You for This Condition / /	Has patient ever had same or similar symptoms? ☐ Yes ☐ No
Date Patient Able to Return to Work	Dates of Total Disability From / / Through / /	Dates of Partial Disability From / / Through / /
Name of Referring Physician		For services related to hospitalization, give hospitalization dates Admitted / / Discharged / /
Name & address of facility where services rendered *(if other than home or office)*		Was laboratory work performed outside your office? ☐ Yes ☐ No Charges:

Diagnosis or nature of illness or injury.
1.
2.
3.
4.

Date of Service	Place of Ser-Vice*	Procedure Code CPT4	Fully describe procedures, medical services or supplies furnished for each date given. (Explain unusual services or circumstances)	ICD9 Diagnosis Code	Charges	
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Signature of Physician or Supplier Signed Date / /	Accept Assignment ☐ Yes ☐ No	Total Charge	Amount Paid	Balance Due
	Your Social Security No.	Physician's or Supplier's Name, Address, Zip Code & Telephone Number		
Your Patient's Account No.	Your Employer I.D. No.	I.D. No.		

*Place of Service Codes

1-(H) -Inpatient Hospital	4-(H) -Patient's Home	7-(NH) -Nursing Facility	O-OL -Other Locations
2-(OH) -Outpatient Hospital	5- -Day Care Facility (PSY)	8-(SNF) -Skilled Nursing Facility	A-IL -Independent Laboratory
3-(O) -Doctor's Office	6- -Night Care Facility	9- -Ambulance	B- -Other Medical Surgical Facilities

Complete each column for each Prescription	Date of Purchase	Prescription Number	Name of Medication	Diagnosis for Which Medicine was Prescribed	Prescribing Physician	Cost *(Excluding Tax)*
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